School-Based Behavioral Health Screening Initiative Provider Referral Form

Student Information	Name:	
Client-identified gender: ☐F ☐M ☐Trans* ☐Other_____	DOB:	SSN (if available):

Address:		Phone:	
City:	County:	State:	Zip:

☐ Parental Custody Name: Phone:	☐ Kinship Care/Relative Placement Name: Phone: Effective Date:	☐ DCBS Custody/ Foster Care Worker name: Phone:	Custodian name: Phone: Effective Date:

Reason for referral/presenting problem for assessment:

☐Substance abuse	☐Peer problems/Bullying or Victim of	☐Traumatic Life Event
☐Anger management	☐Anxiety	☐Unable to focus/Hyperactivity
☐Depression	☐Poor Attendance/Truancy	☐Crisis in School Environment
☐Suicidal/Self-Harm	☐Poor Academic Performance	☐Other (Please specify):

GAIN SS Screening Completed: ☐Yes ☐No If so: Date Completed:_____

Domain	**Past Month**	**Past Year**
Internalizing Disorder	☐Low ☐Medium ☐High	☐Low ☐Medium ☐High
Externalizing Disorder	☐Low ☐Medium ☐High	☐Low ☐Medium ☐High
Substance Disorder	☐Low ☐Medium ☐High	☐Low ☐Medium ☐High
Crime/Violence	☐Low ☐Medium ☐High	☐Low ☐Medium ☐High

Student's Insurance (if available): ☐ Medicaid ☐ Medicare ☐ Private Insurance ☐ None:(Sliding Scale Fee)

Please indicate which MCO or Private Insurance Company client is covered by:

Please ensure the following items are submitted with this referral form or are brought to the student's initial intake appointment:

☐ GAIN SS Summary Report
☐ Client's Medicaid, Medicare or Private Insurance Card (if available)
☐ Release of Information from School

Has parent/caregiver provided consent to screen? ☐ Yes ☐ No

Has parent/caregiver agreed to be contacted by behavioral health provider? ☐ Yes ☐ No

Best time to meet with student during the school day:_____

Please indicate the name of the person accompanying student to the first appointment with behavioral health provider (must be authorized to consent to treatment):

School Name and Address:	Person Completing Form: Email/Phone:
Signature of Person Completing Form:	**Date:**